EXHIBIT A

Department of Law
State of Georgia

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Mr. Donald F. Roof, CFE
Director, Regulatory Services Division
Office of Insurance and Safety Fire Commissioner
7th Floor, West Tower
2 Martin Luther King, Jr. Drive
Atlanta, Georgia 30034

RE: AOM, Incorporated "Pre-paid Primary Care Medical Services Plan"

Dear Mr. Roof:

In your letter of September 6, 2000, you have asked whether the "First Choice Payment Plan Agreement" (the "Plan") proposed by AOM, Incorporated ("AOM"), is subject to regulation by the Department of Insurance (the "Department").

Included in your letter were letters dated November 30, 1999, May 8, 2000, May 19, 2000, and June 26, 2000 from Kristopher R. Schleicher, counsel for AOM, to the Commissioner, a proposed "AOM Physician's Agreement", and marketing brochures.

The Proposed AOM Plan

Based on your letter and the documents enclosed with it, it is my understanding that AOM's plan works as follows:

AOM proposes to market a contract for limited pre-paid medical services, consisting of a maximum of eight visits per year to a specified internal care physician under contract to AOM. These services are generally limited to "the scope of medical care and health care services and procedures customarily provided by primary care physicians, internists, family practice physicians and pediatricians", which I assume to exclude in-patient and hospital services. The patient also receives a 35% discount on the physician for all services not included in the AOM plan. The patient pays $35 a month to AOM and a one-time $15 enrollment fee to AOM. Upon each visit to the doctor, the patient pays an "administrative fee" or co-payment to the physician

of $10, $15 or $20, depending on the length of the visit. The physician also receives a flat fee of $21 a month from AOM for each patient assigned to the physician.

The economic consequences of this arrangement over a one year period, assuming that the patient makes full use of the plan (eight visits per year) and makes an average co-payment of $15 per visit, are as follows:

Cost to Patient:	
• Patient pays 12 monthly payments of $35 to AOM:	$420.00
• Patient pays 8 co-payments of $15 to physician	120.00
• Patient pays enrollment fee of $15 to AOM	15.00
Total	$555.00
Patient's average cost per visit:	$ 69.38
Payments to Physicians (per patient):	
• AOM flat fee to physician per patient: 12 x $21:	$252.00
• Co-payment from patient (avg. $15 for 8 visits):	120.00
Total	$372.00
Average physician income per visit:	$ 46.50

Since AOM's income and its payments to the physician are fixed, AOM does not bear any risk under its plan. It is the physician who bears the risk that a given patient will make full use of the allotted eight visits.

Does the AOM Plan constitute "insurance"?

As defined by O.C.G.A. § 33-1-2(2),

> "Insurance" means a contract which is an integral part of a plan for distributing individual losses whereby one undertakes to indemnify another or to pay a specified amount or benefits upon determinable contingencies.

"Insurer" is defined as:

> any person engaged as indemnitor, surety, or contractor who issues insurance, annuity or endowment contracts, subscriber certificates, or other contracts of insurance by whatever name called. Hospital service nonprofit corporations,

> nonprofit medical service corporations, burial associations, health care plans, and health maintenance organizations are insurers within the meaning of this title.

As interpreted by the courts, and in previous opinions of the Attorney General, the essential elements of insurance have been described as follows:

(1) a contract;
(2) an obligation to indemnify the insured, or to pay specified amounts upon determinable contingencies; and
(3) the contract must be part of a plan involving a number of risks, some of which will involve losses, and of spreading such losses over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it. Bently v. Allstate Ins. Co., 227 Ga 708, 710 (1971); Op, Att'y Gen. 72-62, 89-12.

With regard to the second element, it is well recognized that the benefits of an insurance policy need not be in the form of cash payments. Consideration in the form of services may also constitute insurance "benefits". Op. Att'y Gen. 82-71; 89-12; 74-48 at p. 97.

With regard to the third element, the presence of "risk distribution" has been described as the "*sine qua non* of every insurance contract." Op. Att'y Gen. 74-48 at p. 96; Piedmont Life Ins. Co. v. Bell, 109 Ga. 251, 260 (1964). A common method of analyzing whether the contract under examination contains an element of risk distribution is to compare the maximum benefits available under the contract with the premiums payable. A "disproportionately high ratio" of maximum benefits to premiums is proof that a significant risk distribution is taking place, and thus that the contract should be viewed as insurance. Op. Att'y Gen. 74-98 at p. 96; 76-59 at p. 104. Conversely, where the total payments made by the "insured" are approximately equal to the cost of the benefits, there is no significant risk distribution and the contract should not be viewed as insurance. Op. Att'y Gen. 89-12.

One other principle of law bears mention in any analysis of a possible contract of insurance. Whether or not a contract is one of insurance is determined by the purpose, effect, contents and import of the agreement, and not necessarily by the terminology used therein, though it may contain declarations to the contrary. Benevolent Burial Assoc. Inc. v. Harrison, 181 Ga. 230, 238 (1935); Op. Att'y Gen. 74-48 at p. 95. "The business which the company is actually carrying on, and not the mere form of its organization, is the test for determining whether it is an insurance company within the law applicable to such companies". 181 Ga. at 238; Op. Att'y Gen. 76-59 at p. 104.

These general principles have been applied in a two prior opinions from the Attorney General which are relevant to an analysis of AOM's Plan.

In Op. Att'y Gen. 72-62, the Attorney General analyzed two agreements that were being marketed by an optometrist to determine whether they were contracts of insurance. The first, a "Continuing Contact Lens Service Agreement", was a plan available for a small charge that obligated the optometrist to provide duplicate contact lenses upon request, and to provide "ancillary services" such as fitting and polishing, for a stated monetary fee. It was determined that this plan was not insurance, because it did not involve "the assumption of or the actuarial distribution of a loss risk". Rather, it was "in the nature of an option to purchase a combination of goods and services at a set fee for a stated period of time". Id. at 106.

A different conclusion was reached in regard to the "Continuing Prescription Eyeglass Service Agreement". For a stated upfront fee, the subscriber was entitled to replacement or repair of his glasses during the life of the agreement, for a $5 fee per repair or replacement. This arrangement was held to result in "an express undertaking by the insurer [the optician] to indemnify the patient against a potential loss of uncertain amount", since the "bulk of the premium" was charged up front and the stipulated replacement fee was "so low as to bear no reasonable relationship to the actual replacement cost". Id. at 107.

In Op. Att'y Gen. 82-71, the Attorney General considered three "generic types" of prepaid dental plans. In the first, a fixed price was paid in return for all dental work which might be necessary during the period of the contract. This was held to be insurance, since the premium was "considerably below the cost of the services potentially available to each participant". In the second, a fixed amount was paid in return for the right to receive dental services at reduced cost, usually at 20 to 25% of the normal and customary fees. Such a plan may or may not be insurance, depending on whether the amount charged "at least approximates the dentist's actual cost". If so, no risk distribution is involved and thus no insurance is being offered. In the third plan, referred to as a "capitation plan", the plan paid each dentist a fixed fee for each participant enrolled by that dentist, and the dentist agreed to provide all necessary services for that fixed fee. A capitation plan is considered to be insurance if "the fee charged to participants is highly disproportionate to the maximum benefits theoretically available to participants".

Viewing the AOM Plan in light of those opinions, it appears more likely than not that the Plan is not insurance. AOM is offering what may be described as a modified capitation plan, since it provides for a fixed fee to the physician, but limits the number of patient visits and the scope of services available, and further requires that additional payments be made by the patient to the physician. The key is the relationship between the amount paid by the patient and the value of the maximum services available under the Plan; if you determine that the amounts paid at least roughly approximate the cost or value of the maximum services available, then there is no distribution of risk of loss and the contract is not one of insurance. If you find that the amounts paid are highly disproportionate to the cost or value of the maximum services available, then the

contract should be considered to be insurance, notwithstanding the disclaimers to the contrary in AOM's contracts.

It is also relevant that the structure of AOM and its relationship to the benefit process do not appear to support a finding that it is an insurance company, since its income and expenses are fixed, and it is not involved in any way with a claims or underwriting process. See Op. Att'y Gen 89-12, in which the Attorney General wrote that a dental services "discount plan" does not constitute insurance, where the discounted amount paid for the services was still an approximation of the dentist's cost in providing those services.

Finally, I should note that AOM is not subject to regulation as either an HMO or a "health care corporation". An HMO may or may not qualify as an "insurer". Op. Att'y Gen. 84-87. However, to be considered an HMO, the company must provide all "basic health care services" as defined by O.C.G.A. § 33-21-1(2). See O.C.G.A. § 33-21-3(d)(3). Due to the limited scope of the services available under the AOM Plan, it cannot be considered an HMO. Op. Att'y Gen. 82-71 at pp. 145-6. Nor would AOM be subject to regulation as a "health care corporation", since it is organized for profit. See O.C.G.A. § 33-20-31.

As always, please let me know if you have any questions or concerns.

Sidney R. Barrett, Jr.
Assistant Attorney General

CC Harold D. Melton, Esq.